ABSTRACT

SOCIAL WORK

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DESCRIPTIVE STUDY OF COPING AND ADAPTIVE BEHAVIORS OF FAMILIES WITH MENTALLY ILL FAMILY MEMBERS

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The purpose of this study was to see how parents or guardians cope and adapt to their mentally ill relatives. Primarily, the study set out to identify coping and adaptive behavioral skills that will allow the parents of the mentally ill to better cope and adapt. It also set out to identify specific variables strongly associated with the conditions sampled, they were the family structure, isolation, loneliness, shame, anxiety, fear, psychotic behavior, lack of understanding, anger, quilt, sympathy, compassion, ambivalence, community support and educational approach.

The literature reviewed for this study revealed a number of studies that were mostly dealing with the coping and adaptive skills that will help parents to deal with their mentally ill relatives. The purpose was to explore the real life situations that families of the mentally ill have to endure while working with their mentally ill relative. Further, to determine other circumstances that contribute to the coping and adaption skills of these families.

Forty-seven families participated in the study. The purpose of the survey was to measure the involvement that many families have with their mentally ill relative and how they cope and adapt with their behavior.

The finding of the study seem to indicate no significant difference between the variables. However, many of the families could not cope with the behavior of their mentally ill relative. Direction for future research should include longitudinal studies concerning this topic and this population.

DESCRIPTIVE STUDY OF COPING AND ADAPTIVE BEHAVIORS OF FAMILIES WITH MENTALLY ILL FAMILY MEMBERS

A THESIS

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
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THE MASTER OF SOCIAL WORK DEGREE

BY

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SCHOOL OF SOCIAL WORK

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ACKNOWLEDGEMENTS

This study is dedicated to my deceased best friend, Terri Turner for helping me to understand that life is short and for helping me to understand that all is not possible without God.

This is a study about how families try to deal with mentally ill relatives and what they need in order to continue in their heroic task. The reports of their experiences, conveyed in the stark and honest language of alternating despair and courage, bridge the distance between the two groups of caregivers: Families and professionals.

I am grateful for the unique opportunity to have done such a study. I shall never forget the expressions on the faces on the family members, as I listened in stunned silence to the responses from the mentally ill family member. The visible effects of these responses provided a rare moment of communion with me and a better understanding of my experiences and those of other families. I hope that the readers of this paper will share their compassion and concerns.

Special gratitude goes to Dr. Gale Horton, advisor, for his untiring efforts and guidance throughout the thesis research.

TABLES OF CONTENT

LIST OF TABLES

List of tables, continued

Table Page

CHAPTER I

INTRODUCTION

Modern societies are witnessing rapid advancements in the area of mental health. Accompanying this advancement is a steady decline and regression in the area of families of the mentally ill, especially in the areas of coping and adapting. Mental illness has became an epidemic that, when viewed in absolute terms does not discriminate against any age, color, class, sex or nationality. It is a worldwide problem and characterized by many stigmas. But, the stigmas that many family members face when dealing with their mentally ill relatives is a real fact. However, when mental illness is viewed in relative terms, it can be distinguished across the basic characteristics of color and class.

Typical to this distinction of mental illness is the coping and adapting patterns that the family must undergo in order to support the ill family member. For instance, their caregiving role, their role in supporting other families, their teaching and educational role and their advocacy role in supporting other families with similar problems.

It is also asserted here that manifestations of these types of problems are sometimes ignored, often partially addressed, accepted as a way of life, or simply viewed as a light subject and of not much importance. For instance,

there are many studies that examined the opposition from general society that was encountered by families attempting to cope with mental illness. This should not only be accepted as being dubious support for the family, it should be treated as a way of life. Another dimension of society's acceptance of mental illness as a way of life is described by Rene Grosser and Phyllis Vine as follows:

> Grosser and Vine surveyed 1,612 families that had a mentally ill family member on their perception of the service needs of individuals with psychiatric disabilities that were living in New York State. Concerns about the future was one of the significant effects on the lives of the family members. Most of the respondents with a relative in the hospital thought that a community living situation that provided the same amount of care and support as when the client lived at home would be beneficial for the client. Further, in this study, vocational and work programs were deemed the most important non-residential service needs.[1]

This study will therefore consider two aspects, namely, the coping and adapting skill's of families with mentally ill members. Mental illness is defined as an impaired psychosocial or cognitive functioning due to disturbance in any one or more of the following processes: biological, chemical, psychological, genetic, psychological, social, or environmental. Mental illness is extremely variable in the

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[1]Grosser, Rene and Vine, Phyllis. Families as advocates for the mentally ill: A survey of characteristics and service need, American Journal Of Orthopsychiatry. (April, 1991), Vol. 6(2), 282-290.

duration of it's severity and prognosis, depending on the specific type of affliction.[2]

A study conducted by Coleman revealed statistics on mutual support groups for families of the mentally ill. During this study questionnaire were administered to 99 facilitator's for families of the mentally ill. These questionnaires addressed the group process and effectiveness; The group session were observed and interviews were held with 23 facilitator's and focused on the emotional responses to the stress of an mentally ill person and group characteristics that detract from the healing process. Findings supported the idea that these groups act as a healing agent for this population despite the negative tone evident in many meetings.[3]

A study by Spaniel, Zipple and Lockwood, discusses the multiple roles that families can play in the psychiatric rehabilitation process and suggests ways for professionals to collaborate with them. The family's experience of loss and their process of recovery, their care giving role, and their role in supporting other families.

Such documentation of the numerical rise in the families that are coping with family members that are mentally ill were

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[2]Ibid, pg. 281-290.

[3]Coleman, Marion T., "Mutual Support groups for families of the mentally ill," Marriage And Family Review Journal. (1987). Vol. 11(3-4). 77-93.

exhibited in the previous studies. They also indicate that somehow, methodically, the measures of educating and helping families to eradicate this problem are inadequate. This study will not deviate from past studies of this nature; however, as an explanatory study, it will provide additional knowledge useful for future research on this subject.[4]

STATEMENT OF THE PROBLEM

Literature abounds with documentation about mental illness, but there is a limited amount of information on how families are coping with mentally ill family members. There are also other factors that the families of the mentally ill client face and it is significant to social work because social workers are mediators for families as well as clients.

In a recent study by Joanne Rebschleger on families of chronically mentally ill people in which siblings spoke to social workers. The study consisted of 20 siblings (aged 21-65) that discussed their emotional responses to the mental illness of their bothers or sisters especially in relation to the grief and loss phase of denial, anger, bargaining, depression, relief, respite and acceptance. The clear communication between social workers and family members was important to focus on family strength and effective client intervention. The sibling perspective points out the need for

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[4]Spaniel, Leory., Zipple, Anthony M. and Lockwood, Doris, "The role of family in psychiatric rehabilitation." Journal Of Schizophrenia Bulletin. (1992). Vol. 18(3). 341-347.

social workers to use their ecological perspective in environment training to facilitate healthier family support networks for chronically mentally ill people.

Therefore given the growing number of families that have emotional responses about their mentally ill relative and the increasing number of family members that are crying out for help as a result of the sudden and dramatic onset of the illness, certain questions have to be raised. Only by responding to these questions adequately and effectively can a result be reached.[5]

This study will thus attempt to respond to the following research questions:

(1). What distinguishes family members that play an active part in the lives of the mentally ill client from those that do not play a role.

(2). Do active members and inactive family members of the mentally ill client perceive and assess their experience differently given similar crisis situations.

(3). Is there really some coping and adapting skills that will help families with mentally ill relatives.

SIGNIFICANCE AND PURPOSE OF THE STUDY

The purpose of this study is to explore the factors that are associated with family members that provide care for their mentally ill family members. Many family members are enduring a great deal of frustration while working with their mentally

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[5]Reibschleger, Joanne L., "The Families of chronically mentally ill people; sibling speak to social workers," Health And Social Work Journal. (May 1991). Vol. 16(7), 94-103.

ill relatives and many social workers play the role of the advocate when counseling these families. However, this study will:

(1). To explore the real life situation that families of the mentally ill have to endure while working with their ill relative.

(2). To explore other circumstances that contribute to the coping and adaption skills of these families

HYPOTHESIS

To guide this investigation, the following hypothesis has been formulated.

NULL HYPOTHESIS

(1). There will be no significant difference between families that are involved, with their mentally ill family members than those that are not involved, regarding their interaction, coping skills, adapting skills and their understanding of their relatives illness.

DEPENDENT AND INDEPENDENT VARIABLES

In postulating a relationship between the constructs identified, the variables are categorized in order to facilitate measurement. The variables have been identified as follows:

(1). Dependent Variable Coping and adaptive behaviors of families with mentally ill family members.

(2). Independent Variables The predictors of the condition sampled are family structure, isolation, loneliness, shame, anxiety, fear, psychotic behaviors, lack of understanding, anger, guilt, sympathy, compassion, ambivalence, community support and educational approach.

CHAPTER II

REVIEW OF LITERATURE

INTRODUCTION

Pertinent research studies deemed significant for use in this study relating particularly to variables selected for exploration, were difficult to discern from the studies on the families of the mentally ill because this study is often examined within the areas of home care and mental hospital care. Consequently, layman, students and scholars have to examine the theoretical perspectives of sociologists, psychologists and other medical specialists on mental illness in order to conceptualizes the breadth of this problem.

Hartfield observed that the resistance encountered by families attempting to cope with mental illness is very difficult for many families to face. It is argued that the difficulties families face are due to the nature of the mental health disciplines. These disciplines present resistance to family caregiving due to disunity and diversity in the mental health field, a tendency to explain problems in terms of individual pathology, inadequate theory and method for dealing with catastrophic circumstances, and a failure to protect consumers through self-regulation.[1]

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[1]Hartfield, Anges B. "System resistance to effective family coping." New Direction For Mental Health Service Journal, (1987), Spring. No.(33), 51-62.

Upholding the factors and classifying the families coping and adapting skills into categories on the basis of the family and client relationship, Gubman and Tessler, contended that such classifications are useful in determining predictions of the strengths of certain variables. For example, Gubman and Tessler concluded that mental illness has far-reaching effects on other family members although family impact of mental illness has not received much attention from sociologists.[2]

Notably, the classification of the families into various categories further discerns the degree of severity and review. Depending on the circumstances of the families ability to cope may be fully or partially exonerated of any emotional or mental illness. Controversially, in some cases, years of upset and turmoil precede the full recognition that a family member is suffering from the illness. In other cases, lack of understanding and sometimes denial, avoidance, and distortion prevent families from acknowledging that there is something the matter.

According to Dribbon, one hundred and five subjects, mostly white, married, educated women all members of a support/advocacy network of families of the mentally ill, responded to self-report questionnaires measuring coping style, appraisal of control, locus of control, burden, and

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[2]Gubman, Gayle, Tessler, Richard C. "The Impact of the mental illness on families." Journal of Family Issues. (1987), 47.

depression. The revised ways of coping checklist was employed to ascertain preferred coping style. Generalized locus of control was established by the Internal Control Index and a varying form of the measures for appraisal of situational specific control was incorporated from Flokman and Lazarus. The Center for Epidemiologic Studies- Depression scale was used to evaluate depression and burden was assessed by the Zarit Burden Interview.

Problem-focused coping strategies were found to be associated with less depression and burden than emotion-focused strategies. Result regarding the fit between appraisal of control, coping style, and adaption were directional yet not significant; problem-focused coping was no more adaptive in situations (i.e. problems and experiences resulting from having a mentally ill family member) appraised as controllable as compared with situations appraised as not controllable. Emotion-focused coping was no less adaptive in situations appraised as controllable as compared with situations control and locus of control were not significantly related. Additionally, internal locus of control was associated with less depression and burden. Depression and burden were also positively associated.[3]

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[3]Dibbion, Michael R. "Appraisal of control, Locus-of-control, coping style and their relationship to depression and burden among families of the mentally ill." Dissertation, 1993.

DEMOGRAPHICS AND CHARACTERISTICS OF MENTALLY ILL FAMILIES

Two illustrative studies of families of the mentally ill utilizing the characteristics of race, age diagnosis, sex, etc.: Pat and Bill Williams were two dedicated couple in the California Alliance for the mentally ill (CAMI), they recruited 199 of its members to participate in a survey that produced 10,00 separate answers. Robert Sommer Ph.D undertook the task of doing an in-depth analysis of the data.

These parents have either sons or daughters that receive treatment and have learned a lot about mental illness. This survey consist of parents who really want to take a part in the treatment team and assist in the recovery process but have not always been listened to by professionals.

Diagnosis schizophrenia was by far the most often mentioned diagnosis 66 percent. An additional 17 percent listed it in combination with another mental illness, thus raising the component to 82 percent. Another 10 percent and another 13 percent mentioned it in combination with schizophrenia. Only 3 percent mentioned personality disorder, while 8 percent mentioned it in combination with something else.

Age: The age of the majority of the mentally ill was between twenty-five and thirty-four years: 84 percent were between parents with mental illness.

Age of onset: Almost two-thirds notice onset occurring

between twenty-five and thirty-four: The peak period for severe mental breakdown was in the late teens, 42 percent.

Help was first sought: Two-thirds of the mentally ill between the age fifteen and twenty-four years. Most families sought help almost immediately. The problem was noticed between ages fifteen and nineteen by 42 percent, and 42 percent by responding families sought help that period.

Sex: Almost three-fourths were males, 73 percent. Are males more vulnerable? Does society put more stress on them? Do makes us more street drugs? It is harder to be the parent of a mentally ill son?

Source of assistance: The percentage of those using each source and how helpful each was low.

Clergy, Vocational rehabilitation, and board and care facilities ranked highest in helpfulness but are among the latest available. Many added a note that they wanted work and training that were appropriate for their troubled family member, work with support and low pressure.

Residence: About half, almost 50 percent are currently living at home. Conservatorship Half have at some time been on conservatorship.

Jail: Half have been in jail for some it was only overnight detention until they could get into a hospital.

Other ill relatives: Ten Percent of the parents have mental illness. About ten percent of the father and 7 percent

of the mothers. Ten percent of the sibling had mental illness.

Community residential treatment system (CRTS), those responding approval included in the system were crisis house, long term halfway houses, satellite housing, socialization and vocational rehabilitation centers.[4]

Ferris and Marshall conducted a study dealing with a model project for families of the chronically mentally ill. They found that as frequently the primary caretakers of chronically mentally ill relatives. These families report a variety of stresses. La Frontera Center, Inc., a comprehensive community mental health center in Tucson, Arizona, is currently addressing the needs of these families through the Family support Project. Families in this project have learned how to enhance the lifestyle of their ill family members as well as their own lifestyles by working in groups and focusing on distinct goals.

Services for persons who are chronically mentally ill have traditionally been focused on the identified client. As a result, families of clients have not had equal access to mental health systems unless they were also viewed as clients. Families needs, in relationships to the client, were not identified, nor did families have any way of getting

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[4]Scasha, Michael R. Out of our minds: How to cope with the everyday problem of mental illness. A guide for patients and their families, (1986) Prometheus Book, Buffalo, N.Y., 14-36.

their needs met. Families have typically been identified as a determent to the client-valued neither as a positive factor in treatment nor as a supportive part of the system.

Families, parents, and mothers, in particular, have historically been identified as causative agents in the etiology of mental illness and most professionals, these theories are history; However the stigma of such relief remains, and the literature espousing these theories is available for the distressed family member seeking information. Torrey has referred on families by professionals and has specifically criticized family theorists arguing that they:

> Fail to take into account the family chaos caused by having a mentally ill family member, so that communication and interaction problems caused by the illness are mistakenly perceived as problems causing the Illness.[5]

Kreisman and Joy would concur and have suggested that the "unilateral perspective" of research has led them to neglect research aimed at distinguishing the extent to which attitudes of relatives are a function of the condition of the patients with which whom they reside.[6]

In another study that was conducted by Lukoff, Snyder, Ventura and Neuchterlein concluded that independent life

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[5]Ferris, Patricia A. and Marshall, Catherine A. "A model project for families or the chronically mentally ill." National Association Of Social Workers. (1987) Vol. 32(2), 110-14.

[6]Ibid, pg. 110-114.

events are associated with the onset of schizophrenic episodes among selected subgroups of schizophrenic patients.

Studies finding that life events play a triggering role in schizophrenic episodes fit a simple version of the vulnerability stress model. In this model independent life events functions external stressors which raise a person's stress level. If the level of stress exceeds the threshold for schizophrenic episodes associated with the person's vulnerability level and episodes of psychotic symptoms is precipitated.

However, the fact that life events and family atmosphere may play a role in triggering the onset of schizophrenic episodes tell us very little that is unique about the nature of schizophrenic disorder. The findings regarding family atmosphere and course of illness are not specific to schizophrenic either. Stress seems to act as general area which and acquired vulnerability.

Yet, this review of the research on the life events and familial stress as well as the coping responses literature has uncovered some aspect of the relationship between stress and the course of illness that seem specified characteristics of schizophrenia.[7]

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[7]Lukoff, David., Snyder, Karen., Ventura, Joseph., and Neuchterlein, Keith H., "Life events, familial stress, and coping in the developmental course of schizophrenia." Schizophrenia Bulletin, (1984), 10(2), 258-292.

In another study conducted by Butler and Pritchard which addressed the impact of mental illness upon the individual concluded that in order to understand the impact of mental illness upon an individuals family, there is a need to compartmentalize artificially a process which is in reality a tightly interlocked system which is both inter-active. At the start of the psychiatric breakdown the client may sense a vague feeling of unease, with perhaps uncontrollable ideas breaking into his conscious thoughts. This may create a sense of confusion within the individual's mind and begin to disrupt normal, logical thinking. The individual generally struggles against these imposed ideas and attempts to retain a sense of equilibrium.

In the case of a psychotic experience the very bizarreness of the hallucination may add an extra dimension to the fear that the person is losing control of part of his life. The feeling of bewilderment engendered may lead to a state of anxiety and uncertainty. There then may follow a distortion of communication as the client finds difficulty in expressing himself and in turn in comprehending what others are saying. The disruptive of normal communication may itself then lead to further misunderstanding and difficulties between the client, and his family and other and so a vicious spiral develops.

The individual's self identity is maintained by the responses of other people. In everyday life we all perform a

number of different roles, husbands, bother, worker, etc., in relation to those significant other people in our lives. As a mental illness progress some of these roles may be disrupted, as the individual finds it harder to meet his responsibilities and the exceptions of others.

The impact that a mental disorder may have upon an individual's family's significant others in their life therefore are an important dimension to the problem and one in which a social worker must often involve themselves. Frequently, on first contact the family may appear hostile and defensive and it may be too easy in such circumstances to attribute a degree of blame to them for the disorder. However, a more sympathetic reading of the situation is usually possible. Relatives may have had to endure a good deal of difficult behavior from the client so that what meets the social worker on during the visit may be a good deals of pent up feelings of frustration and anger, tinged within a little guilt.[8]

Oats conducted a study on when the mental patient comes home. He talked about the importance of providing a practical guide for the families, friends, employers, co-workers and others who are suffering from and recovering from mental illness and who, perhaps, have come home form a mental hospital or treatment center.

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[8]Butler, Alan., and Pritchard, Colin. "Impact of mental disorder." Social Work and mental illness. (1983) MacMillian Education, Hong Kong, 29-41.

Oats also stated that he is working to help mentally ill families to become more confident, happier and get more from life. Sometimes seeing things in print clarifies what is going on in a relationship better than guessing. This is true for most of us, whether we have experienced a mental or an emotional disorder or not.

Since so many persons are afflicted at times with psychic disorders, most of us want to learn how to cope more constructively with mental problems. There are times when convalescent-mental patients need help in controlling the attitudes and action. For the most part, however, trying to control recovering patient is not helpful.

Family and friends often wish to protect recovering patients from the full range of human experiences. They seek to insulate patients from sorrow, excitement, fear, and even joy. The fear that "too much" weeping, thrill, fright, laughter, might cause the patient to regress.[9]

Hartfield conducted a study on Family Education In Mental Illness and the changing attitudes of the parents which covered attitudinal changes toward parents with a mentally ill offspring. Now parents are seldom seen as causative agents in their child's tragic disorder, rather they are now seen as an essential part of support and care.

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[9]Oates, Wayne E. "When The Mental Patient Comes Home." (1980). The Westminster Press. Philadelphia, PA., 11-37.

Families spend a lot of time explaining how having mental illness in the family affects them, how various professional behaviors and attitudes can be either hurtful or helpful, and what kinds of practical help they need in order to cope successfully. Consciousness raising has been going on much like it did in other movements. Parents have become particularly resistant to being defined as "psychotic level families", "pathogenic," "dysfunctional," etc. These are negative judgements, that could lead to self-rejection and low self-esteem if families were persuaded of this truth. All people, families of the mentally ill included, strive for a self-image that is acceptable to them.

The clinical manifestations of the various mental illness are presented in great detail in the professional literature. The reality of mental illness for the research scientist or the college professor are the object facts of these disorders, the nature of the brain's malfunctioning, the nature of the thinking disorders, the inappropriate moods, the incapacity of self-core or self-management of daily activities, the bizarre language, the tendencies to withdraw, and so forth. The objective reality of mental illness is certainly one of importance, but it is now the only one. There are realities or way of viewing mental illness for persons who suffer from mental disorders and still a different reality for those who care about the suffers. Mental illness has many personal meanings for those

suffers. Mental illness has many personal meanings for those it touches. The objective facts are given meaning by the personal interpretation assigned to them.

Theorists of coping and adaption recognize the need to understand the interpretative function in crisis situations. The emotional impact of mental illness in terms of the four major areas:

1. The threat of loss of depravation
2. The threat to self-esteem and self-worth.
3. The threat to security.
4. The threat to integrity and hope.[10]

The onset of mental illness has a painful and disorganizing effect on patients as they try to make sense out of their environment and struggle to adjust to a world that now seems to them. Close relatives observe the painful dilemma endured to these seemingly intractable problems.

People with mental illness spend time and effort avoiding ordinary life situations because they find them threatening. Rather than reaching out, confronting new situation, and learning to cope with new realities, they use all their energies to find ways to avoid them. Families have the burden of sorting out what they can do and what they cannot do to improve the life of their ill relative. Furthermore, they must define how much they will give of themselves, or what they will invest.

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[10]Hartfield, Anges B., Family Education in mental illness. Community Mental Health Journal, Vol. 29(2), April, 1993. Human Science Press, New York, 195.

Lefley states that families coping with mental illness requires a shedding of rescue fantasies that in a great part have been nurtured by professionals. It is grandiose for families to believe that they have caused or can cure the phenomenon as a awesome as mental illness. They can only try to modify their behavior to make life more comfortable for themselves and their mentally ill relatives. In spite of the tragedy of mental illness for those who are its, victims, life must go on. Families find themselves needing to construct life so that, not only are they accommodating the patient's special needs, but there is normality and growth for other family members. That this becomes a challenge of inordinate proportion will become clear as we describe some of the intrusive behaviors exhibited by highly disturbed individuals.[11]

Torrey notes that developing the right attitude is the single most important thing a family can do to survive schizophrenia. The right attitude evolves the ideas of schizophrenia-blame and shame. These lie just beneath the surface of many families, impending the family from moving forward, souring relations, between family members, and threatening to explode in a frenzy of finger pointing, accusation, and reclamation.[12]

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[11]Ibid, 34-41.

[12]Torrey, Fuller E. Surviving Schizophrenia: A Family Affair Manual. (1988). Harper and Row Publisher, New York, N.Y., 273-314.

Stern conducted a study about mental illness and the family whenever anyone has been away from home for a while, the family has had to adjust to carrying on without the individual. When he returns, the family has to readjust. The readjustment may be as major as having to quit a satisfying job taken during the emergency to return to housekeeping or as minor as giving up a temporary unused closet that came in so handy for storage. The importance thing is to recognize such frustrations for what they are; then you will not take them out in irritation against the mentally ill family member.[13]

According to Myers and Roberts, the onset of illness has a great impact upon patients and their families. The onset of the illness can be viewed more profitably as part of its development then as merely its end result. The onset is that point in the developmental process where a psychiatric observer diagnoses the patient behavior as disordered. The researchers found significant differences in the reduction of patients and their families to the onset of their symptoms, how they got out into treatment, the therapy process, and the reaction of the patients and their families to the patient and their families to the patient treatment. The patients

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[13]Stern, Edith M., Mental Illness a guide for the family: Keeping the patient in the community. (1968). Harper and row publisher, New York, N.Y., 26-32.

generally sought help for that symptoms and persisted for some time and becomes extremely bothersome. However, neither they nor their families accepted the idea their illness were nonphysical.[14]

Roen conducted a study on the families and the ill parents. There were 253 families in the three studies. The ill parents in these studies were mostly middle-aged. They were equally divided between ill fathers, ill mothers in one-parent families. More than three fourth of the ill mothers were not living with the husbands, most of them for reasons of separation. The results of the study revealed that two-thirds of the parents were between the ages of 25 and 44 years. One-third was below 25 years and a equal number over 45 years. One-sixth were fathers. They were older than the mother by 4.9 years, mother who had no husbands at home were younger than the ill mothers with husbands in the home.[15]

According to stern and Hamilton at one time or other some members of one of every five families in the United States behave so abnormally that they end up in a mental hospital. Yet, almost every time mental illness strike in any form, there is much unnecessary suffering for both relatives and patient's because most of us are so unprepared and

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[14]Myers, Jerome K. and Roberts, Bertram H. Family and class Dynamics in mental illness.. (1959) John Wiley and Son, Inc., New York, N.Y., 219-222.

[15]Roen, Sheldon Children Of the Mentally Ill Parents. (1971) Behavioral Publications, New York, N.Y. 39-70.

bewildered when one of our loved ones cease to be themselves, so ignorant of the medical resources for restoring him to normality and of the way mental hospitals are set up people get well. In mental illness especially, the attitudes of relatives play a large part for better or for worse. Therefore, your family members chances for recovery will be markedly increased if you look upon him as ill instead of well but wicked.

Family members will, also, spare themselves much self-torture and help speed your loved ones along the road to mental health if you realize that mental illness is not a disgrace, that no more stigma should be attached to a disordered mind that to disordered digestion or circulation the sheer fact of the disorder is hard enough to bear. The family members must complicate and magnify them for all concerned by coloring them with ideas that date from the days when insanity was believed to be caused by visitation from demons to call in help because of false shame.

It does not mean that the family is dsyfunctioning because one of its members has a mental breakdown. Remember that even the sturdiest tree have weak branches and that therefore if you have a mental patient in your family it does not follow that all the rest are doomed. Face the truth of the relative's condition frankly, do not gloss it over by maintaining "there really nothing wrong with him" or he's just acting up" but do not aggravate the problem with sorrow

that come inevitably and sorrow that comes inevitably with any illness by direct speculations about anxious observations of your normal relative.[16]

According to Schwartz and et.al perhaps most important of the family may play a role in helping the patient, a role often denied them in more conventional treatment. Another difference is that one type of service required the helper to go to the patient, whereas in the other the patient seeks the service. In general, it seems that coverage will be reduced if help depends largely on the patient's seeking it. In this respect, treatment in the community may be more of an innovation and reach a different population of disturbed persons than emergency treatment in clinics. When the service goes to the patient, less effort is required of him and his family and more is required of community caretakers. However, there is a need for more experience with families and patients to assist them with meeting the needs of their family members.[17]

According to Hansell, in many cultures, the family of persons-in-distress is assembled at the time of an illness to participate in the assessment of the situation. Family members are provided opportunities to carry on tasks deemed

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[16]Stern, Edith M. and Hamilton, Samuel W., Mental illness: A Guide for the family.. (1945)., Oxford University Press. New York, N.Y., 9-15.

[17]Schwart, Morris S., Schwartz, Charlotte G., Social Approaches To Mental Patient Care. (1964), Columbia University Press, New York and London, pg. 45-80.

intrinsic to the recovery of the afflicted. In this way, a renewal of attachments is fostered at a time when such attachment otherwise might falter. The unmanaged distress of any individual distress in other members of his/her family unit, often resulting in psychosomatic symptoms or in deteriorated role performance in many members of the unit. Consequently, the family members may be adaptionally overextended. Such a fact has often led professionals to separate a distressing member from the rest of his family.[18]

According to Kessler and Goldston, family functioning in the Stony Brook sample was also more disturbed among the two patients group studied in several areas: Family solidarity, children's relations, household facilities and financial circumstances. The two patients group did not differ from one another in these respects. The parent characteristic, are viewed by their children, as instructive. Schizophrenic mothers were considered to be more accepting and child-centered and depressed mother more child-centered than were normal-mothers. Schizophrenic fathers were perceived as more negative (i.e. unaccepting and uninvolved) than normal fathers, whereas, depressed fathers were not different from the normal.

As a result of the study it was concluded that interactions between a child and a parent are reciprocal.

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[18]Hansell, Norris. The personality distress on the biosoical dynamic of adaption. (1976) Behavioral publications, New York, N.Y. 98-113.

Frequent actions directed to one person matched by frequent actions in return. Hence it was surmised that the relationship to a nonpatient parent has important compensating potential for healthy development of the offspring.[19]

According to Parmelbe and Katz they had a new away of looking at the concepts of caregiving to the depressed older persons. The body of research on the burdens and rewards of caregiving to elderly individuals who suffer disabling physical illness or dementia is already substantial.

The article examines families of the patient for major depression to determine what was most difficult and most rewarding about their interaction with the patient and to evaluate the extent of difficulties that were related to the outcome of the patient's illnesses. This article also raises concerns not only about how much of the family burden was related to the process of hospitalization rather than the illnesses, but also about the extent to which the findings are relevant to patients with less severe depression.

As a result of the article it provided a broad perspective to help the family to understand the patients illness and recognize the distinction between the person and

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[19]Kessler, Marc and Goldston, Stephen E. A Decade Of Progress In Primary Prevention, (1986) University press, New England, 51-159.

the disease, and respond appropriately to the patient's disability and care needs.[20]

Hanson and Rapp conducted a study on families perceptions of Community Mental Health programs for their relatives with severe mental illness. This study discussed the realization that families are providing a major portion of the care for people with a severe and persistent mental illness has led to attempts to form an alliance with such families. Many professionals are aware that there is much cognitive distance between families and the professional community. As a result the confluence of the need for improved techniques of community care with the realization that the family is providing much care has contributed to attempts to seek alliance with families of people with mental illness.[21]

In a study conducted by Lefley, he talked about the family burden and family stigma in major mental illness. The literature on stressful life events devotes for less attention to continuous or chronic stressors than to discrete events.

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[20]Parmelee, Patricia and Katz, Ira "Caregiving to depressed older persons:A relevant Concept? The Gerontologists. (1992) Vol. 32(4), 436-437.

[21]Hanson, James G., and Rapp, Charles A. Families Perception of community mental health programs for their relatives with a severe mental illness. Community Mental Health Journal. Vol. 28(3) June, (1992), 181-186.

As a result, surveys of family experiences show the effects of stress on the psychological and sometimes the physical health of caregivers, inability of caregivers to make their worries about what will happen to the patient "when I am gone," particularly among elderly patients or chronic patients. Relatives also report the agony of decisions about involuntary commitment of persons whose behavior or self-neglect may be life-threatening and guilt about leaving a loved one in a hospital or community placement of inferior quality and unhappy choices that the patient may resent and hold against them.

Perhaps the most devastating stress for families, however, is learning how to cope with the patient's own anguish over an impoverished life. Even regressed patients are often aware of their impaired functioning and poor future prospects in relation to others in their age group.[22]

In a study conducted by Beardsless, Hoke et.al., regarding the initial findings on preventive intervention for families with parental affective disorders. The objective of this study was to develop a clinician-based cognitive, psychoeducational, preventive intervention for families with parental affective disorders that would be suitable to widespread use, test its feasibility and safety, and define the areas affected by the intervention designed to increase

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[22]Lefley, Harriet P. Family Burden and Family Stigma in major mental illness (1989) American Psychologists Vol. 44(3), 556-560.

understanding of parental illness and reliance in the children.

Beadless studied the first seven families (14 parents) to receive the intervention. Enrollment criteria included affective disorders during the proceeding year in at least one parent, presence of at least one child between the age of 8 and 14 years who was not psychiatrically ill all the time of participation, and willingness to participate in the research study. As a result the overall satisfaction with the intervention was rated moderate to high by parents. No harm was reported. Ten of 14 parents subjects reported five or more behavior attitude changes that they attributed to the intervention. The most frequent behavior and attitudinal changes reported were increased discussion of the illness and related stress on family members when it boiled down to understanding the illness of their family member. The authors concluded that the intervention is safe and feasible in families with children that have mental disorders.[23]

In an article by Hanson and Rapp concerning the care of family members and the help that community mental health centers are providing to help families cope with some of the difficulties. Many mental health programs realize that families are providing a major portion of the care for their relatives with mental illness. Attention is given to the

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[23]Beardless, William R., et.al. Initial findings of preventive interventive disorders. (October,1992) American Journal Of Psychiatry 149(10), 1335-1340.

families experience and needs for changes in practice which address curriculum strategies for adequately preparing future cadres of mental health professionals.

As a result, more initiative has been exercised in trying to understand the family experience of dealing with family burdens while working with mentally ill members of their family. Much of this work deals with the generalized burden with family members with severe mental illness. Although less work has been done relative to families' perception of the more discrete components of the intervention cycle. Such as hospitalization and community programs, and their contribution to the burden of the family.[24]

According to Moorman, in her book: "My Sister's Keeper: To Cope With A Sibling's Mental Illness,", discussed the devastating effect of her older sister's mental illness on their family. Suffering from manic-depressive disorder, Sally became the focus of her patient's attention. Poisonous arguments between Sally and her symbiotically involved mother, punctuated by fights between her parents, racked their upper-middle-class suburban home during Peggy's childhood and teens. The family denied the illness, even her existence, while at the time identifying unhappiness. As a

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[24]Hanson, James G. and Rapp, Charles. A Families perception of community relatives with severe mental illness. (1990) Community Mental Health Journal. Vol. 28, No(3), 181-184.

result the author concludes that the book succeeds as a brave, poignant memoir of a difficult coming-of-age, as a lifeline to sibling of the mentally ill and as a crucial addiction to the literature on the subject.[25]

According to Green et.at., one of the major gaps in studies of families of persons with schizophrenia is an understanding of the long-term effects that the burden associated with coping with mental illness have on parental health. In this study, data were gathers from a sample of 81 mothers of adult children with schizophrenia. The results revealed that subjective burdens associated with stigma and worries are related to lower levels of physical well-being.

As a result the understanding of such impact on families with members having mental illness is increasing as several changes in treatment systems and society in general leads more families, in particular parents, to assume caregiving responsibilities for their adult children with mental illness. Researchers also suggest that family members may seek treatment for health problems exacerbated by the stress of caregiving.[26]

According to Garson in a study dealing with how families cope with everyday problems of the mentally ill. In the study

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[25]Mourman, Margaret. My Sister's Keeper: Learning To Cope With A Sibling's Mental Illness. (February, 1992), Vol. 239(8), 66.

[26]Greenberg, Jane S. et.al., Mothers Caring For An Adult CHild With Schizophrenia. Family Relations Journal, (1983), 42, 205-211.

it stated that more and more of behavior are being defined as psychotic in nature. For parents whose children suffer from mental illness, the question of what is really crazy" takes on great import. They know that something is terribly wrong with their children and to see them alone, withdrawn, unable to cope with life's minimal demands, cringing in fear and fleeing from imagined pursuit and despairing life. He explains the origin and nature of schizophrenia, depression manic depression, and the behavior that accompanies them in language the layperson can understand.

As a result of the book provided a practical guide to symptoms recognition. Crisis management, patient's rights, the rights of the family, and an overview of innovative socialization and work rehabilitation programs. It is very helpful and much needed for parent trying to cope with the everyday problems and emergencies of their mentally ill relative.[27]

In a study conducted by Guberman et.al he talked about family caregivers and why they care? The study was based on in-depth quality interviews with 40 family caregivers of mentally ill relatives and focused on their caregiving relation rather than on the specificities of the mental illness. Data indicated that analyses attempting to

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[27]Garson, Sascha. Out of our minds: How to cope with everyday problems of the mentally ill. A guide for patient's and their families. Buffalo, N.Y., Prometheus Books, (1986), 282.

understand caregiving must take into account the different adjust the caregiver will have to make in order to help that ill member of the family.

As a result, Guberman and others came up with the conclusion that many mentally ill patients receive most of their care from their families and since families generally do care, that is, care about the well-being of kin, they often find themselves caring for these persons as well. Since it is considered "natural" for families to care about each other, it seems "natural" that they assume the tasks linked to caring for that ill family member even though most of the time it is very stressful and the caregiver cannot cope with all of the added responsibilities.[28]

According to East, elaborated about how over seven-year period the family involvement model helped maintain more than 120 people with sever chronic mental illness in the community. Many of these client required brief hospitalization; some needed long-term hospitalization, but all of the clients returned to their families to a apartment where they were taken care of by one or more family members. The family involvement approach was not perfect. Not all clients who entered a day treatment program are able to be helped. Some committed suicide; others needed frequent hospitalization.

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[28]Guberman, Nancy. et.al. Women as family caregivers: Why do they care? The Gerontologist. (1992), Vol. 32(5), 607-617.

On the other hand, ignoring the families of chronically mentally ill adults or children because they are angry, hopeless, and rejecting can be a serious mistake. Families involved in different activities that the client may have can be very helpful. There are a number of family-centered programs, but what they fail to realize is that working with a mentally ill family member is very stressful and it puts a lot a pressure upon the family and sometimes they cannot cope and they will try to find a way out. A majority of the time the mentally ill client is sent to a day program in order to give that family a rest and to give them a opportunity to adapt to the illness more to help that family member when they return to the home. Even though that ill family member may have rejecting behaviors that family continues to play a vital role in maintaining residual connections.[29]

THEORETICAL FRAMEWORK

The families of the mentally ill has been investigated by distinguished scholars utilizing various theoretical approaches. Lefley in a article on the impact of mental illness in families described the family burden and coping strategies through questionnaires in 84 experienced mental health families members who were suffering from chronic mental

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[29] Family as a resource: Maintaining chronically mentally ill members in the community. National Association Of Social Workers. Vol. 17(2), 93-96.

illness.[30] Lefley made significant contributions to families of the mentally ill and made in-roads for other works such as Gubman and Tessler in a study on the impact of mental illness on families: Gubman and Tessler, however, deviated from Lefley by saying that:

> "Mental illness has far reaching effects on other family members although family impact of mental illness has not received much attention from sociologists, applies on illness behavior perspective to the study of family, burden, reviews knowledge, and invites knowledge, and invites research by defining a number of issues, substantive and methodical, that need to be addressed."[31]

Barnard and Stafford, on the other hand conducted a study on families and the chronically mentally ill in rural settings. They examined the important considerations for a family therapist working with rural families of mentally ill persons, by reviewing current issues in family therapy. They also describe recent research and practical matters associated with service delivery to rural families, case study identifies service provided to chronically mentally ill clients and her rural family.[32]

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[30]Lefley, Harriet P., "Impact Of Mental Illness on families of mental health professionals," Journal Of Nervous And Mental Disease, (1987) 613-619.

[31]Gubman, Gayle D., Tessler, Richard C., "The Imapct of mental illness on families. Journal Of Family Issues, (June, 1991), Vol. 8(2), 226-245.

[32]Barnard, Charles P., Stafford, Dianna, "Families and the chronically mentally ill in rural settings. Human Service In Rural Environment Journal. (1987) Vol. 12(4), 14-18.

Deserving mention but not necessarily establishing any frameworks for this study are Miller, Dworkin, Ward, and Barone that conducted a preliminary study of unresolved grief in families of seriously mentally ill patients. These authors asserted that:

> "Investigation of the grief reactions experienced by families when a relative develops a serious mental illness have been hampered by the devised mentally ill version of the Texas inventory of grief, adaption from the Texas revised inventory of grief, to assess family members initial and present feelings about their relative's loss of mental health. A test of the instrument with 58 family members of patients with schizophrenia or bipolar disorder revealed a low level of initial grief but higher levels of present grief. Results suggest that families of severely mentally ill persons may undergo a delayed grief reaction.[33]

Of the theoretical anthropologists, the one which most nearly parallels the model described here is the Bicultural Model that Anthony Wallace posits that the initial cause of mental illness is physiological, but that the cultural "mazeways," (cognitive maps) profoundly shape the course of illness. In some detail, he notes how the "theories" of illness of the sick individual, his family and associates, and the professional impinge on illness as a behavior system. The chief components of a "theory" of illness are to be:

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[33]Miller, Fredrick, Dowkin, Joan, Ward, Michael, Barone, Deidre. "A preliminary Study Of unresolved grief In families of seriously mentally ill patients."Hospital And Community Psychiatry Journal. (December 1990) Vol. 41(12), 132-325.

1. The specific states (normalcy, upset, psychosis, in treatment, and innovative personality).

2. The transfer mechanism which explains (to the satisfaction of the member of the society) how the sick person moves from one state to another.

3. The program of illness and recovery which is described by the whole system.[34]

The Ecological Approach is used because it deals with concepts about transactions between people and their environment, adaption, reciprocity, mutuality, stress, and coping. It also considers growth and development, identity, compence, autonomy, and relatedness. This approaches uses Erikson which is concerned with environment quality, organizations and social network.

The assessment is carried out by the worker and client together seeking to understand meaning; focus on person and problem in order to set objectives and devise appropriate action. engages positive forces in client and environment. Attempts to remove environmental obstacles and change negative transactions. Uses a process of engagement, exploration, contracting, ongoing, ending. Concerned with client need and vulnerability. Focus on life transition, unresponsiveness of environments, crisis events, and communication-relationship difficulties. Action designed to increase self-esteem and problem-solving and coping skills. Also to facilitate group

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[34]Thomas, J. Scheff., Being Mentally Ill A Sociological Theory. Adline Publishing Company, Chicago, Il, (1966), 14-15.

functioning and influence organizational structure, social networks, and physical settings.[35]

TERMS AND DEFINITIONS

1. Mental Illness - Mental illness is defined as an impaired psychosocial or cognitive functioning due to disturbance in any one or more of the following processes: biological, chemical, psychological, genetic, psychological, social, or environmental. Mental illness is extremely variable in duration of it's severity and prognosis, depending on the specific type of affixation.

2. Families - Are groups of people sharing a common ancestry or lineage.

3. Isolation - To separate from a group or whole and set apart: The act of isolating.

4. Loneliness - Without compassion; Infrequently with people; Desolate.

5. Anxiety- A state of uneasiness and distress about future uncertainties; apprehensions; Worry.

6. Fear- An emotion of alarm and agitation caused by expectation or realization of anger.

7. Anger- A feeling of extreme displeasure, hostility, indignation, or exasperation toward someone or something, rage, wrath.

8. Guilt - The fact of being responsible for an offense of wrongdoing.

9. Sympathy - A relationship or affinity between persons or things in which whatever affects one correspondingly affects the other.

10. Compassion - The deep feeling of sharing the suffering of another, together with the inclination to give aid or support to show mercy.

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[35]Germain, Carl B., Gitterman, Alex. The Life Model Approach To Social Work Practice Revisited," in France J. Turner, Ed., Social work Treatment: Interlocking Theoretical Approaches, 2nd ed., (New York: The Free press, 1986), pp. 618-644.

11. Ambivalence - The existence of mutually conflicting feelings or thoughts, such as love and hate, about some person, object or idea.[35]

[35]American Heritage Dictionary. Houghton Mufflin Company, (1991) 2nd ed.

CHAPTER III

METHODOLOGY

The research design employed in this study is know as the descriptive or explanatory design. This research design is utilized for the development of social technology or in formation, selection, evaluation and assembly of relevant basic information for purpose of technological innovation.[1]

Families of the mentally ill coping and adapting were selected and compared on a number of independent variables. The inquiry was conducted retrospectively, to analyze how the mentally ill coping and adapting skills related to such demographics characteristics as education, lifestyle, family structure, physical violence, family relationship and control. The families of the mentally ill were tested to see if they could actually cope or adapt to their mentally ill relative.

INSTRUMENT DESIGN

The questionnaire utilized in this study is an original questionnaire developed by the author. The questionnaire has thirty questions related to family involvement, techniques and methods that were identified by the interaction approach. The questionnaire was developed to measure the degree to which a person copes or adapts to their mentally ill relatives.

The items in the questionnaire were ranked from 1 (never) to 7 (always) and the support for the instrument's validity

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[1]Grinnell, Richard M. Social Work Research Evaluation Itasca, Illinois: F.E. Peacock Publishers, Inc., 1981), 601.

is based on the average from each of the results. Appendix A contains a copy of the questionnaire.

THE SAMPLE

The sample consisted of (47) forty-seven families that had a least one member receiving treatment at a Mental Health facility. All subjects were at the time, families of patients in Skyland Trail rehabilitation program or ComCare Housing, Inc. Program, both located here in Atltanta Georgia. Both programs were utilized to collect the data for this study.

The selection criteria for the sample required that they:

(1). Must be a family.

(2). Must have a family member receiving treatment at a Mental Health facility.

(3). Must answer the questions on the questionnaire and send the questionnaire back.

The purpose was provided to the sample once and the questionnaire was hand delivered and were completed and returned to the author within a week time period.

METHOD OF ANALYSIS

The method of analysis that comprised this study consisted of descriptive and inferential statistics. The descriptive statistics in this study included frequency distributions, the mean and standard deviation. The SPSS-X batch system was used to analyze the data. To test the research hypothesis, a correlation was done measure what contact each family had with their mentally ill relatives.

The data obtained in this study was coded into computer and analyzed by the use of the Statistical Package For The Social Sciences.[2]

[2]Nie, N., et. al., Statistical Package For The Social Sciences. 2nd ed., 1985. New York: McGraw-Hill.

CHAPTER 4

FINDINGS

FREQUENCY DISTRIBUTIONS

Frequency distributions were utilized to demonstrate percentages of responses. See tables I-XIX.

TABLE I

Descriptive study of coping and adaptive behaviors of families with mentally ill family members.

1. I feel good about my family member.

10.9%	Never	
23.9%	Very Rarely	
43.5%	Most of the time	
21.7%	Always	
	Mean 2.761	Std. Dev. .923

2. My family member gets on my nerves.

15.2%	Never	
45.7%	Very Rarely	
37.0%	Most of the time	
2.2%	Always	
	Mean: 2.261	Std. Dev. .743

3. I feel like he/she is a stranger in the family.

30.4%	Never	
34.8%	Very Rarely	
28.3%	Most of the time	
6.5%	Always	
	Mean: 2.109	Std. Dev. .924

4. I don't understand his/her illness.

14.4%	Never V	
28.3%	Very Rarely	
32.6%	Most of the time	
21.7%	Always	
	Mean: 2.587	Std. Dev. 1.024

5. Thee is a lot of friction when he/she is around.

15.2%	Never	
30.4%	Very Rarely	
39.1%	Most of the time	
15.2%	Always	
	Mean: 2.543	Std. Dev. .936

Table I, Continued

6. We get along when he/she is around.

13.0%	Never	
23.9%	Very Rarely	
43.5%	Most of the time	
19.6%	Always	
	Mean: 2.696	Std. Dev. .940

7. I take a part in his/her activities.

10.9%	Never	
43.5%	Very Rarely	
41.3%	Most of the time	
2.2%	Always	
	Mean: 2.356	Std. Dev. .712

8. I really don't care for him her to be around.

17.4%	Never	
34.8%	Very Rarely	
8.7%	Most of the time	
2.2%	Always	
	Mean: 2.378	Std. Dev. .886

9. I think that he/she is terrific.

43.%	Never	
19.6%	Very Rarely	
50.0%	Most of the time	
26.1%	Always	
	Mean: 2.978	Std. Dev. .802

10. His/Her behavior embarrasses me.

23.9%	Never	
37.0%	Very Rarely	
32.6%	Most of the time	
6.5%	Always	
	Mean: 2.217	Std. Dev. .892

11. I feel ashamed of him/her.

32.6%	Never	
34.8%	Very Rarely	
23.9%	Most of the time	
8.7%	Always	
	Mean 2.087	Std. Dev. .962

12. I wish I did not have him/her.

37.0%	Never	
34.8%	Very Rarely	
17.4%	Most of the time	
2.2%	Always	
	MEan: 1.978	Std. Dev. .965

Table I, Continued

13. I like being with him/her.

8.7%	Never	
26.1%	Very Rarely	
39.1%	Most of the time	
2.2%	Always	
	Mean: 2.800	Std. Dev. .919

14. I wish he/she was more like others I know.

21.7%	Never	
43.5%	Very Rarely	
17.4%	Most of the time	
17.4%	Always	
	Mean: 2.304	Std. Dev. 1.008

15. I get upset when he/she is around.

17.4%	Never	
30.4%	Very Rarely	
43.5%	Most of the time	
8.7%	Always	
	Mean: 2.435	Std. Dev. .886

16. He/she is a real joy to me.

4.3%	Never	
17.4%	Very Rarely	
52.2%	Most of the time	
26.1%	Always	
	Mean: 3.000	Std. Dev. .789

17. He/she is too much to handle.

8.7%	Never	
41.3%	Very Rarely	
34.8%	Most of the time	
15.2%	Always	
	Mean: 2.565	Std. Dev. .860

18. I cannot cope with his her behavior.

19.6%	Never	
34.8%	Very Rarely	
41.3%	Most of the time	
4.3%	Always	
	Mean: 2.304	Std. Dev. .840

19. I play a vital role in his her treatment program.

15.2%	Never	
50.0%	Very Rarely	
23.9%	Most of the time	
2.2%	Always	
	Mean: 2.267	Std. Dev. .837

Table I, Continued

20. I think that he/she should be separated from the rest of the family.

15.25	Never	
56.5%	Very Rarely	
28.3%	Most of the time	
2.2%	Always	
	Mean: 2.130	Std. Dev. .653

21. I feel that I cannot take care of him/her.

17.4%	Never	
15.2%	Very Rarely	
54.3%	Most of the time	
13.0%	Always	
	Mean: 2.630	Std. Dev. .928

22. I understand the difference between him/her and their illness.

8.7%	Never	
17.4%	Very Rarely	
47.8%	Most of the time	
26.1%	Always	
	Mean: 2.913	Std. Dev. .890

23. I am providing most of his/her care.

19.6%	Never	
19.6%	Very Rarely	
37.0%	Most of the time	
4.3%	Always	
	Mean: 2.591	Std. Dev. 1.041

24. There is a lot of distance between us.

6.5%	Never	
47.8%	Very Rarely	
32.6%	Most of the time	
13.0%	Always	
	Mean: 2.522	Std. Dev. .809

25. I need help with him/her.

10.9%	Never	
10.9%	Very rarely	
43.5%	Most of the time	
34.8%	Always	
	Mean: 3.002	Std. Dev. .954

26. My life has been altered by him/her.

26.1%	Never	
30.4%	Very Rarely	
13.0%	Most of the time	
2.2%	Always	
	Mean: 2.444	Std. Dev. 1.179

Table I, Continued

27. He/she resents me.

19.6%	Never	
30.4%	Very Rarely	
45.7%	Most of the time	
4.3%	Always	
	Mean: 2.348	Std. Dev. .849

28. I am satisfied with him/her.

13.0%	Never	
26.1%	Very Rarely	
39.1%	Most of the time	
4.3%	Always	
	Mean: 2.636	Std. Dev. .942

29. I fight with him/her.

23.9%	Never	
32.6%	Very Rarely	
26.1%	Most of the time	
2.2%	Always	
	Mean: 2.333	Std. Dev. 1.002

30. I have health problems because of him/her.

32.6%	Never	
41.3%	Very Rarely	
4.3%	Most of the time	
2.2%	Always	
	Mean: 1.956	Std. Dev. .852

31. There is no interaction or communication between us.

10.9%	Never	
45.7%	Very Rarely	
34.8%	Most of the time	
2.2%	Always	
	Mean: 2.378	Std. Dev. .777

32. I become very stressful when working with him/her.

10.9%	Never	
32.6%	Very Rarely	
32.6%	Most of the time	
2.2%	Always	
	Mean: 2.667	Std. Dev. .953

33. The onset of his/her illness had a great impact on our family.

13.0%	Never	
23.9%	Very Rarely	
30.4%	Most of the time	
2.2%	Always	
	Mean: 2.800	Std. Dev. 1.036

Table I, Continued

34. I blame myself for his her disorder.

32.6%	Never	
26.1%	Very Rarely	
23.9%	Most of the time	
2.2%	Always	
	Mean: 2.222	Std. Dev. 1.085

35. I have to endure many changes when he/she is around.

8.7%	Never	
39.1%	Very Rarely	
41.3%	Most of the time	
10.9%	Always	
	Mean: 2.543	Std. Dev. .808

36. I feel obligated for his/her care.

15.2%	Never	
21.7%	Very Rarely	
32.6%	Most of the time	
28.3%	Always	
	Mean: 2.756	Std. Dev. 1.048

37. I am experiencing financial hardship because of him/her.

17.4%	Never	
41.3%	Very Rarely	
23.9%	Most of the time	
17.4%	Always	
	Mean: 2.413	Std. Dev. .979

38. I have added responsibilities when he/she is around.

13.0%	Never	
17.4%	Very Rarely	
28.3%	Most of the time	
41.3%	Always	
	Mean: 2.978	Std. Dev. 1.064

39. There is a lot of pressure in the family because of him/her.

10.9%	Never	
26.1%	Very Rarely	
30.4%	Most of the time	
32.6%	Always	
	Mean: 2.848	Std. Dev. 1.010

40. Outside agencies help me a lot with him/her.

8.7%	Never	
13.0%	Very Rarely	
32.6%	Most of the time	
45.7%	Always	
	Mean 3.152	Std. Dev. .9665

FREQUENCY DISTRIBUTION FINDINGS

The findings from frequency distributions indicated that ten percent of the families felt good about their mentally ill family members, even though fifteen percent of the time the ill family member got on their nerves. Thirty percent of the families felt that their family member was considered as being strange and seventeen percent really did not understand their illness. It was discovered that fifteen percent of the families experienced friction when their ill family member was around and over thirteen percent stated that they got along well when he or she was around.

The findings demonstrated that ten percent took a part in their mentally ill relatives activities, seventeen percent did not care for them to be around and four percent thought that he/se was terrific. Twenty-three percent of the families felt that his/her behavior embarrassed them and thirty-two percent felt ashamed of him or her. Due to the fact that some of the families were ashamed of their mentally ill relative thirty-seven percent of them wished that their mentally ill relative was never born.

The findings from the frequency chart indicated that eight percent of the families liked to be with their mentally ill relative, twenty-one percent wished that he/she was more like others that they knew and seventeen percent became easily upset when he or she was around. It was discovered that four percent of the families felt that their mentally ill relative

was a joy to them and eight percent stated that he/she was too much to handle.

The frequency distribution also demonstrated that nineteen percent of the families could not cope with his/her behavior, fifteen percent played a vital part in their family members treatment program and fifteen percent thought that he/she should be separated from the rest of the family.

Seventeen percent of the families of the mentally ill stated that they could not afford to take care of their mentally ill relatives, eight percent felt that they did not understand the difference between the mentally ill relative and their illness and around nineteen percent were providing most of their care. Six percent stated that there was a lot of distance between them and their family members and ten percent stated that they needed help with their mentally ill relative.

Twenty-six percent of the families stated that there life had bee altered because of their mentally ill relative, nineteen percent thought that their mentally ill relative resented them and thirteen percent of the families were satisfied with him/her. The frequency distribution revealed that twenty-three percent of the mentally ill families fought with their mentally ill relative. Thirty-two percent developed health problems because of their ill relative. Ten percent of the families had no interaction with their mentally ill relative and ten percent became very stressful when working

with their ill relative. Thirteen percent of the families stated that the onset of their mentally ill family member had a great impact on their family. Thirty-two percent of the families blamed themselves for their mentally ill relatives illness, eight percent had to endure many changes because if his/her behavior and fifteen percent felt obligated their care.

Seventeen percent of the families studied stated that they were experiencing financial hardship because of their mentally ill relative, thirteen percent had added responsibilities when they were around and ten percent said that there was a lot of pressure on the family when he or she was around. Eight percent stated that outside agencies were a big help to them.

In postulating a relationship between the constructs identified, the variables are categorized in order to facilitate the measurements. The results are as follows, see Tables X-XIX:

TABLE II

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Get on my nerves	Pearsons 'r' Value
1. I feel good about my family member.	.001
3. I feel like he/she is a stranger in the family.	.161
4. I don't understand his/her illness.	.934*
5. There is a lot of friction when he/she is around.	.977*
8. I really don't care for him/her to be around.	.191
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.447
14. I wish he/she was more like others I know.	.709*
15. I get easily upset when he/she is around.	.928*
16. He/she is a real joy to me.	.067
19. I play a vital role in his her treatment program.	.201
20. He/she should be separated form the of the family.	....
22. I understand him/herr and their illness.	.016
24. There is a lot of distance between us.	.353
25. I need help with him/her.	.853
29. I fight with him/her.	.931*
30. I have health problems because of him/her.	....
31. We do not communicate or interact together.	.742
40. Outside agencies help me a lot with him/her.	.185

P<.05

Table III

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Get along when around	Pearsons 'r' Values
1. I feel good about my family member.	.217
3. I feel like he/she is a stranger in the family.	.707*
4. I don't understand his/her illness.	.185
5. There is a lot of friction when he/she is around.	.000
8. I really don't care for him/her to be around.	.024
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.061
14. I wish he/she was more like others I know.	.419
15. I get easily upset when he/she is around.	.000
16. He/she is a real joy to me.	.651*
19. I play a vital role in his her treatment program.	.788*
20. He/she should be separated form the of the family.	....
22. I understand him/herr and their illness.	.920*
24. There is a lot of distance between us.	.025
25. I need help with him/her.	.012
27. he/she resents me.	.001
29. I fight with him/her.	.020
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.319
40. Outside agencies help me a lot with him/her.	.372

P<.05

TABLE IV

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Take part on activities	Pearsons 'r' Values
1. I feel good about my family member.	.756*
3. I feel like he/she is a stranger in the family.	.631*
4. I don't understand his/her illness.	.289
5. There is a lot of friction when he/she is around.	.555*
8. I really don't care for him/her to be around.	.480
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.286
14. I wish he/she was more like others I know.	.023
15. I get easily upset when he/she is around.	.769*
16. He/she is a real joy to me.	.059
19. I play a vital role in his her treatment program.	.178
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.185
24. There is a lot of distance between us.	.658*
25. I need help with him/her.	.207
27. he/she resents me.	.749*
29. I fight with him/her.	.638*
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.184
40. Outside agencies help me a lot with him/her.	.118

P<.05

TABLE V

Bivariate Analysis Of The Dependent And Independent Variable

Variable: You are Terrific	Pearsons 'r' Values
1. I feel good about my family member.	.607*
3. I feel like he/she is a stranger in the family.	.438
4. I don't understand his/her illness.	.805*
5. There is a lot of friction when he/she is around.	.345
8. I really don't care for him/her to be around.	.651*
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.116
14. I wish he/she was more like others I know.	.452
15. I get easily upset when he/she is around.	.566*
16. He/she is a real joy to me.	.049
19. I play a vital role in his her treatment program.	.947*
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.871*
24. There is a lot of distance between us.	.008
25. I need help with him/her.	.392
27. he/she resents me.	.007
29. I fight with him/her.	.002
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.751*
40. Outside agencies help me a lot with him/her.	.041

P<.05

TABLE VI

Bivariate Analysis Of The Dependent And Independent Variable

Variable: You embarrass me	Pearsons 'r' Values
1. I feel good about my family member.	.825*
3. I feel like he/she is a stranger in the family.	.607*
4. I don't understand his/her illness.	.408
5. There is a lot of friction when he/she is around.	.758*
8. I really don't care for him/her to be around.	.073
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.000
14. I wish he/she was more like others I know.	.009
15. I get easily upset when he/she is around.	.163
16. He/she is a real joy to me.	.439
19. I play a vital role in his her treatment program.	.768*
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their Illness.	.213
24. There is a lot of distance between us.	.067
25. I need help with him/her.	.029
27. he/she resents me.	.386
29. I fight with him/her.	.007
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.204
40. Outside agencies help me a lot with him/her.	.280

P<.05

TABLE VII

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Wish didn't have	Pearsons 'r' Values
1. I feel good about my family member.	.006
3. I feel like he/she is a stranger in the family.	.012
4. I don't understand his/her illness.	.452
5. There is a lot of friction when he/she is around.	.317
8. I really don't care for him/her to be around.	.007
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.002
14. I wish he/she was more like others I know.	.623*
15. I get easily upset when he/she is around.	.073
16. He/she is a real joy to me.	.237
19. I play a vital role in his her treatment program.	.163
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.715*
24. There is a lot of distance between us.	.433
25. I need help with him/her.	.018
27. he/she resents me.	.008
29. I fight with him/her.	.012
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.215
40. Outside agencies help me a lot with him/her.	.501*

P<.05

TABLE VIII

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Too much to handle	Pearsons 'r' Values
1. I feel good about my family member.	.005
3. I feel like he/she is a stranger in the family.	.989*
4. I don't understand his/her illness.	.675*
5. There is a lot of friction when he/she is around.	.247
8. I really don't care for him/her to be around.	.028
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.025
14. I wish he/she was more like others I know.	.009
15. I get easily upset when he/she is around.	.163
16. He/she is a real joy to me.	.439
19. I play a vital role in his her treatment program.	.768*
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.213
24. There is a lot of distance between us.	.067
25. I need help with him/her.	.029
27. he/she resents me.	.386
29. I fight with him/her.	.007
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.204
40. Outside agencies help me a lot with him/her.	.280

P<.05

TABLE XI

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Cannot cope with behavior	Pearsons 'r' Values
1. I feel good about my family member.	.080
3. I feel like he/she is a stranger in the family.	.614*
4. I don't understand his/her illness.	.762*
5. There is a lot of friction when he/she is around.	.026
8. I really don't care for him/her to be around.	.600*
11. I feel ashamed of him/her.	.....
13. I like being with him/her.	.142
14. I wish he/she was more like others I know.	.377
15. I get easily upset when he/she is around.	.004
16. He/she is a real joy to me.	.137
19. I play a vital role in his her treatment program.	.364
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.208
24. There is a lot of distance between us.	.202
25. I need help with him/her.	.001
27. he/she resents me.	.027
29. I fight with him/her.	.001
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.360
40. Outside agencies help me a lot with him/her.	.460

P<.05

TABLE X

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Provide his/her care	Pearsons 'r' Values
1. I feel good about my family member.	.840*
3. I feel like he/she is a stranger in the family.	.611*
4. I don't understand his/her illness.	.171
5. There is a lot of friction when he/she is around.	.115
8. I really don't care for him/her to be around.	.200
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.096
14. I wish he/she was more like others I know.	.257
15. I get easily upset when he/she is around.	.001
16. He/she is a real joy to me.	.245
19. I play a vital role in his her treatment program.	.939*
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.045
24. There is a lot of distance between us.	.920
25. I need help with him/her.	.016
27. he/she resents me.	.016
29. I fight with him/her.	.022
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us	.752*
40. Outside agencies help me a lot with him/her.	.400

P<.05

TABLE XI

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Life altered by him/her	Pearsons 'r' Values
1. I feel good about my family member.	.293
3. I feel like he/she is a stranger in the family.	.734*
4. I don't understand his/her illness.	.616*
5. There is a lot of friction when he/she is around.	.051
8. I really don't care for him/her to be around.	.662*
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.117
14. I wish he/she was more like others I know.	.785*
15. I get easily upset when he/she is around.	.130
16. He/she is a real joy to me.	.778*
19. I play a vital role in his her treatment program.	.735*
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.411
24. There is a lot of distance between us.	.006
25. I need help with him/her.	.019
27. he/she resents me.	.092
29. I fight with him/her.	.628*
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us	.624*
40. Outside agencies help me a lot with him/her.	.020

P<.05

TABLE XII

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Satisfies with him/her	Pearsons 'r' Values
1. I feel good about my family member.	.179
3. I feel like he/she is a stranger in the family.	.091
4. I don't understand his/her illness.	.373
5. There is a lot of friction when he/she is around.	.031
8. I really don't care for him/her to be around.	.412
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.053
14. I wish he/she was more like others I know.	.812*
15. I get easily upset when he/she is around.	.004
16. He/she is a real joy to me.	.122
19. I play a vital role in his her treatment program.	.550*
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.455
24. There is a lot of distance between us.	.006
25. I need help with him/her.	.000
27. he/she resents me.	.000
29. I fight with him/her.	.002
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.189
40. Outside agencies help me a lot with him/her.	.243

P<.05

Table XIII

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Stressful when working with	Pearsons 'r' Value
1. I feel good about my family member.	.003
3. I feel like he/she is a stranger in the family.	.993*
4. I don't understand his/her illness.	.090
5. There is a lot of friction when he/she is around.	.005
8. I really don't care for him/her to be around.	.399
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.891*
14. I wish he/she was more like others I know.	.189
15. I get easily upset when he/she is around.	.013
16. He/she is a real joy to me.	.049
19. I play a vital role in his her treatment program.	.618*
20. I think that he/she should be separated form the rest of the family.	.....
22. I understand the difference between him/her and their illness.	.122
24. There is a lot of distance between us.	.593*
25. I need help with him/her.	.045
27. he/she resents me.	.000
29. I fight with him/her.	.002
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.901*
40. Outside agencies help me a lot with him/her.	.403

P<.05

Table XIV

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Illness has impact on family	Pearsons 'r' Values
1. I feel good about my family member.	.951
3. I feel like he/she is a stranger in the family.	.612
4. I don't understand his/her illness.	.064
5. There is a lot of friction when he/she is around.	.485
8. I really don't care for him/her to be around.	.849*
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.040
14. I wish he/she was more like others I know.	.014
15. I get easily upset when he/she is around.	.442
16. He/she is a real joy to me.	.769*
19. I play a vital role in his her treatment program.	.337
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.256
24. There is a lot of distance between us.	.681*
25. I need help with him/her.	.283
27. he/she resents me.	.737*
29. I fight with him/her.	.674*
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.110
40. Outside agencies help me a lot with him/her.	.287

P<.05

Table XV

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Blame myself for the disorder	Pearsons 'r' Values
1. I feel good about my family member.	.272
3. I feel like he/she is a stranger in the family.	.958*
4. I don't understand his/her illness.	.573*
5. There is a lot of friction when he/she is around.	.000
8. I really don't care for him/her to be around.	.117
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.929*
14. I wish he/she was more like others I know.	.782*
15. I get easily upset when he/she is around.	.001
16. He/she is a real joy to me.	.723*
19. I play a vital role in his her treatment program.	.556*
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.517*
24. There is a lot of distance between us.	.587*
25. I need help with him/her.	.061
27. he/she resents me.	.162
29. I fight with him/her.	.026
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.117
40. Outside agencies help me a lot with him/her.	.200

P<.05

Table XVI

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Many changes in his/her disorder	Pearsons 'r' Values
1. I feel good about my family member.	.630*
3. I feel like he/she is a stranger in the family.	.288
4. I don't understand his/her illness.	.403
5. There is a lot of friction when he/she is around.	.087
8. I really don't care for him/her to be around.	.026
11. I feel ashamed of him/her.	....
13. I like being with him/her.	.441
14. I wish he/she was more like others I know.	.492
15. I get easily upset when he/she is around.	.004
16. He/she is a real joy to me.	.497
19. I play a vital role in his her treatment program.	.210
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.411
24. There is a lot of distance between us.	.005
25. I need help with him/her.	.110
27. he/she resents me.	.007
29. I fight with him/her.	.744*
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.073
40. Outside agencies help me a lot with him/her.	.920*

P<.05

Table XVII

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Obligated for his/her care	Pearsons 'r' Value
1. I feel good about my family member.	.006
3. I feel like he/she is a stranger in the family.	.228
4. I don't understand his/her illness.	.062
5. There is a lot of friction when he/she is around.	.021
8. I really don't care for him/her to be around.	.239
11. I feel ashamed of him/her.	.....
13. I like being with him/her.	.968*
14. I wish he/she was more like others I know.	.277
15. I get easily upset when he/she is around.	.026
16. He/she is a real joy to me.	.007
19. I play a vital role in his her treatment program.	.636*
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.077
24. There is a lot of distance between us.	.924*
25. I need help with him/her.	.005
27. he/she resents me.	.003
29. I fight with him/her.	.363
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.296
40. Outside agencies help me a lot with him/her.	.414

P<.05

Table XVIII

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Had financial hardship	Pearsons 'r' Values
1. I feel good about my family member.	.419
3. I feel like he/she is a stranger in the family.	.040
4. I don't understand his/her illness.	.921*
5. There is a lot of friction when he/she is around.	.705*
8. I really don't care for him/her to be around.	.379
11. I feel ashamed of him/her.	.....
13. I like being with him/her.	.888*
14. I wish he/she was more like others I know.	.417
15. I get easily upset when he/she is around.	.141
*. He/she is a real joy to me.	.328
19. I play a vital role in his her treatment program.	.600*
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.561*
24. There is a lot of distance between us.	.251
25. I need help with him/her.	.002
27. he/she resents me.	.153
29. I fight with him/her.	.328
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.818*
40. Outside agencies help me a lot with him/her.	.521*

P<.05

Table XIX

Bivariate Analysis Of The Dependent And Independent Variable

Variable: Lost of pressure on family	Pearsons 'r' Values
1. I feel good about my family member.	.977*
3. I feel like he/she is a stranger in the family.	.901*
4. I don't understand his/her illness.	.614*
5. There is a lot of friction when he/she is around.	.044
8. I really don't care for him/her to be around.	.471
11. I feel ashamed of him/her.	.....
13. I like being with him/her.	.909*
14. I wish he/she was more like others I know.	.571*
15. I get easily upset when he/she is around.	.007
16. He/she is a real joy to me.	.739*
19. I play a vital role in his her treatment program.	.280
20. I think that he/she should be separated form the rest of the family.	....
22. I understand the difference between him/her and their illness.	.659*
24. There is a lot of distance between us.	.002
25. I need help with him/her.	.011
27. he/she resents me.	.052
29. I fight with him/her.	.177
30. I have health problems because of him/her.	....
31. There is no interaction or communication between us.	.262
40. Outside agencies help me a lot with him/her.	.412

P<.05

FINDINGS OF THE BIVARIATE ANALYSIS

The finding of the bivariate analysis demonstrated that no correlation existed between the families and the interaction with their mentally ill relatives. The findings of the bivariate analysis did indicate a moderate correlation between the times that the mentally ill family member got on their families nerves and hoe the family felt about him/her after the situation was over.

The findings of the bivariate analysis did indicate a strong correlation between the how much the families got along with their ill family member and how much they felt like they were considered a stranger in the family. There was a very strong correlation between the families that took a part in their ill family member activities and how much the family understood about their illness.

There is a very strong correlation between the families that thought that their mentally ill family member were terrific and the amount of friction that was experienced when he/she was around. There was a very strong correlation between how some family members felt embarrassed when their mentally ill family member was around and those family member that did not care for him/her to be around at all. A very strong correlation was indicated between the number of families that wished that they did not have their mentally ill relatives and those that loved to with their ill relative. A very strong

correlation was demonstrated between the independent variable that their mentally ill relative was too much to handle and those families that thought that their mentally ill family member was too much to handle. There was a very strong correlation between the independent variable that the families could not cope with their mentally ill realties behavior and the those families that wished that he/she was more like others that they knew.

A strong correlation was indicated between the independent variable that the families were providing most of their mentally ill family members care and how the families became upset when he/she was around. There is a strong correlation between the families whose lives have been altered because of their mentally ill family members and those that played a vital role in his/her treatment programs.

There is a strong correlation between the number of families that are satisfied with their mentally ill family member and those families that felt that he/she should be separated from the rest of their family. There was a weak correlation between the families that were very stressful when working with their mentally il family members and those families that understood the difference between their ill relative and their illness. There was a weak correlation between the impact that the situation was having on the families and the amount of distance between the families and their ill family members. There was a very strong correlation

between the number of families that blamed themselves for his/her illness and the number of families that needed help with their ill relatives.

There was a strong correlation between the independent variable that many families had to endure many changes in their family members disorder and the families that felt that their ill family member resented them. There was a strong correlation between the number of families that felt obligated for his/her care and those family members that always fought with their family members.

There was a strong correlation between the families that had financial hardship because of his/her ill relative and those that had no interaction between their ill family member. There is a very strong correlation between he number of families that had a lot of pressure on them because of their ill family member and the amount of help that they received from outside agencies.

CHAPTER V

CONCLUSION AND SUMMARY

This chapter presents the characteristics of the sample; the statistical analysis performs on the data obtained from the mailed questionnaire; and a discussion of the findings of this study as they relate to the research question and the literature reviewed. The results includes a demographic analysis of the data and composite percentages of the most satisfied respondents.

This study focused on coping and adaptive behaviors of families with mentally ill family members which has become one of the leading issues in the United States today in the area of Mental Health. Many families lack coping and adapting skill, therefore there is limited family involvement with their mentally ill family member. The investigation set out to establish contributory factors to this situation. Included in the investigation were inquiries about the family structure, isolation, loneliness, shame, anxiety, fear, psychotic behaviors, lack of understanding, anger, quilt, sympathy, compassion, ambivalence, community support and educational approach. For example, how do the families that are involved with their mentally ill relative cope and adapt with their behavior from the rest of the families that are not directly involved with their relatives.

It was expected that the responses would be skewed toward a lower scale as a result of their involvement with their

mentally ill relatives. The results however indicated that involvement has a great impact an this measurement. Also the research hypothesis was supported by the result of the study. The statistical analysis indicated that mentally ill families had no coping and adaptive skills to work with their mentally ill relatives. The findings was consistent with previous studies reported in chapter two, which indicated that coping and adaptive skills are needed to help parents to deal with their mentally ill relatives.

Of the dimensions studied, perceptions of family involvement was addressed. This finding was somewhat surprising, given the commonly accepted findings appears to be consistent with the literature reviewed for this study. This might have resulted from the way the question were phrased within the Family Involvement Index, or reflective of the concept itself.

IMPLICATIONS

Further research to determine which variables cause differences between the group under study and the general population is of utmost importance. Therefore, this study does provide an alternative approach to future research on families of the mentally ill, and preventive measures can be developed.

The similarities and differences between measures of mentally ill families indicate a need for social work researchers to carefully develop assessment of the families.

Additionally. findings, which appear to suggest some

inconsistency with earlier research, supported a positive relationship between greater job satisfaction and older workers with shorter period seniority.

Finally, the implications for research in social work practice with families of the mentally ill are to expand existing insight into the long term impact of mentally ill families and further investigation on how families cope and adapt to their ill relatives.

The purpose of social work is to enhance the quality of life for all persons. There are various types of programs throughout the United States that are designed to assist the individuals economics conditions, but rarely address the psychological needs that are equal importance.

The researcher believes that families of the mentally ill should be given the opportunity to improve their coping and adaptive skills for themselves and their children by securing the proper help from public agencies.

This study produced usable qualitative results, especially for social workers who plan to pursue any career involving working with the families of the mentally ill or mental health. Social workers with an interest in this type of intervention should consider including training and counseling that enhance self-concept. Developing social worker should be encouraged to coordinate existing resources to create new opportunities that will adequately equip their clients to succeed in achieving a quality life-style.

For policy, planning administration (PPA) students and policy makers in general these conclusions must be converted to action if the study is to have tangible results in lives of the families of the mentally ill.

Further research to determine which variabless cause differences between the group under study and the general population is of utmost importance. Therefore, this study does provides an alternative approach to future research on families of the mentally ill, and preventive measures that can be developed.

RECOMMENDATIONS

Given the implications of this study, it is recommended that:

1. Future research should build on the present study to determine the factors which impact perceptions of mentally ill families and their coping and adaptive skills, respectively.
2. Studies should be conducted to carefully develop effective coping and adaptive skills that measure a greater assessment of the relationship between the families and their mentally ill relative.

APPENDIX A

CASE NUMBER_____ DATE_____

INDEX OF FAMILY INVOLVEMENT

This questionnaire is designed to measure your involvement with the mentally ill member of your family. It is not a test. There are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1 = Never
2 = Very rarely
3 = Most of the time
4 = Always

Please begin:

1.	I feel good about my family member.	1 2 3 4
2.	My family gets on my nerves.	1 2 3 4
3.	I feel like he/she is a stranger in the family.	1 2 3 4
4.	I don't understand his/her illness.	1 2 3 4
5.	There is a lot of friction when he/she is around.	1 2 3 4
6.	We get along when he/she is around.	1 2 3 4
7.	I take a part in his/her activities.	1 2 3 4
8.	I really don't care for him/her to be around.	1 2 3 4
9.	I think he/she is terrific.	1 2 3 4
10.	His/her behavior embarrasses me.	1 2 3 4
11.	I feel ashamed of him/her.	1 2 3 4
12.	I wish I did not have him/her.	1 2 3 4
13.	I like being with him/her.	1 2 3 4
14.	I wish he/she was more like others I know.	1 2 3 4
15.	I get easily upset when he/she is around.	1 2 3 4
16.	He/she is a real joy to me.	1 2 3 4
17.	He/she is to much to handle.	1 2 3 4
18.	I cannot cope with his/her behavior.	1 2 3 4
19.	I play a vital role in his/her treatment program.	1 2 3 4
20.	I think he/she should be separated from the rest of the family	1 2 3 4
21.	I cannot afford to take care of him/her.	1 2 3 4
22.	I understand the difference between him/her and their illness.	1 2 3 4
23.	I am providing most of his/her care.	1 2 3 4

APPENDIX A, CONTINUED

24.	There is a lot of distance between us.	1 2 3 4
25.	I need help with him/her.	1 2 3 4
26.	My life has been altered by him/her.	1 2 3 4
27.	He/she resents me.	1 2 3 4
28.	I am satisfied with him/her.	1 2 3 4
29.	I fight with him/her.	1 2 3 4
30.	I have health problems because of him/her.	1 2 3 4
31.	There is no interaction or communication between us.	1 2 3 4
32.	I become very stressful when working with him/her.	1 2 3 4
33.	The onset of his/her illness had a great impact on our family.	1 2 3 4
34.	I blame myself for his/her disorder	1 2 3 4
35.	I have to endure many changes in his/her behavior when he/she is around.	1 2 3 4
36.	I feel obligated to his/her care.	1 2 3 4
37.	I am experiencing financial hardship because of him/her.	1 2 3 4
38.	I have added responsibilities when he/she is around.	1 2 3 4
39.	There is a lot of pressure on the family because of him/her.	1 2 3 4
40.	Outside agencies help me a lot with him/her.	1 2 3 4

APPENDIX B

November 11, 1993

Mrs. Drewnell Thomas
Director Of ComCare Housing, Inc.
509 Edgewood Ave. Suite 502
Atlanta, Georgia 30312

Dear Mrs. Thomas:

I am a graduate student matriculating through Clark Atlanta University's School Of Social Work, and I am conducting a research/study to examine the coping and adaption skills of families of the mentally ill clients. It is intended as a partial fulfillment for the requirements of the Master Of Social Work Degree.

In this venture, I am requesting a copy of your mailing list of all addresses of your client's families. I am also requesting your permission to conduct this study using your mailing list.

The purpose of my study is to gain further insight into the skills and altitudes associated with the care of mentally ill family members or relatives.

Thank You for your cooperation and help in this urgent matter.I hope to hear from you soon.

Sincerely,

Janon S. Wilson

Janon Shunta Wilson

Dr. Gale Horton, Ph.D
Thesis Advisor

APPENDIX C

November 11, 1993

Mrs. Beth Finnerty
Skyland Trail Social Rehabilitation Program
2573 Skyland Trail N.E.
Atlanta, Georgia 30319

Dear Mrs. Finnerty:

I am a graduate student matriculating through Clark Atlanta University's School Of Social Work, and I am conducting a research/study to examine the coping and adaption skills of families of the mentally ill clients. It is intended as a partial fulfillment for the requirements of the Master Of Social Work Degree.

In this venture, I am requesting a copy of your mailing list of all addresses of your client's families. I am also requesting your permission to conduct this study using your mailing list.

The purpose of my study is to gain further insight into the skills and altitudes associated with the care of mentally ill family members or relatives.

Thank You for your cooperation and help in this urgent matter.I hope to hear from you soon.

Sincerely,

Janon S. Wilson

Janon Shunta Wilson

Dr. Gale Horton, Ph.D
Thesis Advisor

APPENDIX D

December 10, 1993

Dear Respondent:

I am a graduate student at Clark Atlanta University School Of Social Work, and I am conducting a study to measure the coping and adaption skills of families that have mentally ill family members. I will be deeply grateful if you would participate in this study by completing the attached questionnaire.

I fully understand that the information I am seeking is highly personal and will be kept confidential to insure that no one will be able to recognize your individual responses, I am confident that your voluntary participation in this research will make a significant contribution to the enhancement of issues on families of the mentally ill.

Please answer each item as carefully and accurately as possible. Please complete the questionnaire within this week and if you do not wish to complete it, please return it to the person administering it.

Thank you for your participation in this endeavor.

Sincerely,

Janon S. Wilson

Janon Shunta Wilson

JW/

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